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OCT 18 1947

107 no 2780

BULLETIN of the MENNINGER CLINIC

Vol. 11, No. 1 January, 1947

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Topeka
Kansas

Issued bi-monthly by the Menninger Foundation, Topeka, Kansas
Annual Subscription rate $2.00. Single numbers, 50c
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Science
Psychology
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BULLETIN of the
MENNINGER CLINIC

VOLUME 11 JANUARY, 1947 NUMBER 1

A PSYCHIATRIC TREATMENT PROGRAM IN COMBAT*

By M. RALPH KAUFMAN, M.D.,† and LINDSAY E. BEATON, M.D.‡

The purpose of this report is to present an essentially professional resume of a psychiatric treatment program previously planned and carried out under combat conditions during the Philippine campaign. The whole plan was formulated on the basis of observation and experience in previous campaigns in the Pacific and the reports from other theatres, to the effect that the most valuable therapeutic results in the psychiatric cases precipitated by combat, are obtained from treatment in the combat zone. It called for the formation of a mobile psychiatric team. Four trained psychiatrists, Lt. Colonel (then Major) Howard Gilbert, Lt. Col. (then Major) Charles Smith, Lt. Colonel (then Major) Lindsay Beaton and Captain A. Jackman constituted the team. In addition, four division psychiatrists and Captain Charles Furniss of one of the field hospitals cooperated in the program. In this way, one psychiatrist was made available for each of the field hospitals attached to the divisions. The senior writer, then consultant neuropsychiatrist, Pacific Ocean Areas, and the consultant neuropsychiatrist of the Tenth Army, Lieutenant Colonel Oscar B. Markey, acted in a supervisory and directive capacity.

The aim was to provide psychiatric treatment at the foremost echelon possible at the earliest possible time. Some cases could be treated at the battalion and regimental aid stations; others were to be sent to the clearing company at which the division psychiatrist was stationed. Eventually a policy was inaugurated that allowed for a two to three day stay in the clearing company, during which the patient was given reassurance, hot showers, change of clothes, hot drinks, meals, and sleep under sedation, if necessary. Individual and group psychotherapy within limits of the time and personnel available were instituted. Patients requiring further treatment and those to be evacuated were sent to the field hospitals. During the staging period on Leyte it was deemed advisable to make some changes in the original treatment program which called for sedation at all echelons

* Read at the Section of Psychiatry of The New York Academy of Medicine, May 12, 1946.

† Psychiatrist, The Mount Sinai Hospital, New York, N. Y.
‡ Tucson, Arizona.

and it was decided to dispense, insofar as possible, with the use of chemical sedation at the field hospital level and to substitute hypnosis.

Details of Organization

Each field hospital had an officer from the psychiatric team attached. Each installation assigned four to six enlisted men to be trained in the techniques of handling psychiatric patients. It was originally planned to devote a minimum of fifty beds per hospital to psychiatry. This, however, proved wholly inadequate because of the large number of psychiatric problems. At times there were as many as two hundred patients on a section. Recreational facilities, Red Cross activities and group psychotherapy were part of the program. Emphasis was laid on psychotherapy.

One field hospital came ashore on L plus 1 and set up facilities for handling psychiatric patients in a squad tent. The clearing station of one of the divisions came ashore the same day and the next day began to admit patients. A clearing company of another division came ashore on L plus 1 and after several moves, set up hot showers, barber shop and recreational facilities.

The field hospitals were between four to six thousand yards from the front lines, surrounded of necessity, by our own artillery batteries, firing constantly. They were within range of enemy artillery, as was the whole rear area. Air raids and flak presented a constant threat. This is brought out not as a criticism of the location of hospitals, but to show under what conditions it was necessary to treat the patients. The facilities of the field hospital, although small, were, at first, adequate. The clearing companies, however, began to increase their case load and the pressure of all cases was such at the clearing company, that it was necessary to limit the psychiatric beds to forty. The overflow and cases needing more intensive treatment were sent to the field hospital. This resulted in a marked overcrowding of the psychiatric section. It was recommended on L plus 8 that a field hospital be converted to an exclusively psychiatric treatment center. This hospital had two young officers who had some psychiatric training. Three psychiatrists from the psychiatric team and a trained social worker, a T/5 from the Office of the Surgeon, Tenth Army, were also attached to the hospital.

Therapeutic Program

It was recognized that the therapeutic aim was limited to the working through of the immediate traumatic experiences and that one was not justified in thinking in terms of 'cures'. The problem was rather one of the restoration of personality equilibrium. No attempt was made to

deal with life-long neurotic problems present in the patients. From the military point of view it was essential to return a man to duty as soon as possible. However, it was important to do this only with those soldiers who would remain effective and not break down as soon as re-exposed to combat.

The therapeutic program was based on certain fundamental psychological principles. The so-called combat neuroses occur in individuals subjected to the stresses and strains of battle. Each individual has his own breaking point, provided the pressure is intense enough. Many factors enter into the process—exhaustion, type of combat, the terrain, concentration of fire, particularly artillery and mortar, ambush, being pinned-down by fire, loss of 'buddies', fear of being killed or mutilated, guilt over killing, fear of showing fear to avoid the stigma of being thought cowardly. Others are: morale, leadership, extent of training, knowledge of weapons, self-confidence, *esprit de corps*, presence or absence of team work, identification with the unit, attitude toward the war, the number of campaigns, the time for rest and rehabilitation. These indicate only some of the many overt and subtle factors which play a role.

It is important to realize, in order to understand the basic therapeutic assumption, that in addition to the above contributing causes, that faculty of the human mind which enables men to create phantasies in which the dangers and horrors of war are magnified endlessly may be as significant as actual danger. There is a reactivation of anxiety-laden childhood phantasies and conflicts which tend to link up with the current situations. The adequacy or inadequacy with which these earlier conflicts had been handled by the individual may be related to the 'breaking point' in combat. There is, however, no one-to-one correlation between previous neurotic difficulties or personality traits and the precipitation of a combat neurosis. Many neurotic individuals show a surprising tolerance for their neurosis during the impact of combat, whereas others tend to react to a minimum of combat stress with a full-blown neurosis. The difference between the civilian and military situations may lie in the factor of 'morale' and all that it implies.

The constant tension resulting from the human desire to get away from overwhelming danger while at the same time, wishing to do one's duty, is another great source of conflict. Loyalty to 'buddies,' officers and unit are all forces tending to make a soldier hold on and fight, but these are countered by privation, and threats of imminent death and mutilation. The concept that the combat neuroses are psychologically determined, and therefore susceptible to psychological treatment was basic and led to the utilization of simple well-known psychological principles of therapy.

The soldier who breaks down, usually does so, *not* because he is a coward; quite the contrary, it is because he attempts to continue in the face of a

biological situation that at times becomes overwhelming. The natural instinct for self-preservation must be put into the background. This conflict, added to others indicated above, finally is resolved by the clinical manifestations called by the euphemism "combat fatigue".* It is caused by the soldier's desire to fight and not to run away. A prominent symptom seen in many cases is amnesia which may apply to a single traumatic experience or to the blocking out of that experience plus whole sections of the individual's life. The therapy consists in part of using various techniques to break through to this experience so that it may be relived and mastered. The techniques that help the patient relive his experience vary. Our method of choice was hypnosis. The experiences of the authors had confirmed certain theoretical considerations as to the fallacy of the use of sedation, except as an emergency expedient. The presenting symptoms of many of the patients were confusion and amnesia. The sedatives added to both of these. It was no uncommon sight to see patients stagger about as if drunk on barbiturates, confused and with an amnesia that was fixed by the drugs. This frequently interfered with the possibility of clearing up the amnesia, which was one of the aims of treatment.

The technique utilized for hypnosis was a rather simple one. There was no attempt to fixate the eyes nor were any of the usual maneuvers used. The patient was usually told he was to be hypnotized, if time was available. He would be asked if he knew anything about hypnosis. If objections were present, which was only on rare occasions, these were countered by an explanation. The soldier was told repeatedly, in a low voice, that he would relax and go to sleep. Heaviness of the eyes was suggested. At times this was reinforced by a stroking of the forehead and eyes but this was necessary in relatively few cases. As a general rule, it was possible to put patients to sleep within one or two minutes. In some instances a longer time was necessary. On the whole, the vast majority of patients seemed to be easily hypnotized. We knew of only three patients who were not put to sleep in this way. There may have been many more, but generally the technique was surprisingly successful. As far as we know, hypnosis had not been utilized in this way heretofore in combat during this war.

The use of chemical sedation also led to a lack of that interpersonal relationship which is one of the most essential factors in therapy. Under hypnosis, the soldier may begin to reenact his battle experiences as if they were in the present. His feelings, thoughts, measures for defense,

* The term 'combat fatigue' gained wide-spread usage throughout the Service and is utilized in this paper only for that reason. The authors have rather strong theoretical objections to this diagnostic category and feel that its use was one of expediency rather than nosology.

his fears, are brought out, the physician participating in various roles. Skill is required to evaluate the amount of emotion which can be tolerated at any given moment. Part of the treatment always aims to dissipate the amnesias. There are many clinical manifestations, somatic symptoms, tremors, sweating, heart palpitation, gastric complaints and marked startle patterns in reaction to sudden noises. The helplessness and need for comfort, reassurance and security result in almost childlike reactions in the relationship to the therapist. It is, therefore, important to establish a sort of parent-child (doctor-patient, officer-man) relationship on the first contact with the patient. Reassurance, a kindly but firm approach, and the technique of hypnosis, make for such a relationship. The medical officer introduced himself as "Doctor", never using his rank.

The patient, where possible, was met in the receiving tent. The more agitated the patient, the easier it was to reassure him by hypnosis. In many cases this was accepted readily, the patient being put into a comfortable, restful sleep without the use of drugs. It was also possible by suggestion to block out extraneous stimuli such as sound of gunfire, etc. In most of the other cases this was accomplished soon after the patient was brought to the ward. This use of hypnosis served the immediate purpose of allaying fear and the symptoms of fear. It must be remembered that the treatment took place in a combat area, with all the stimuli of warfare. Repeated assurance of the relative safety of the hospital and the security from momentary danger given as part of the parent-child relationship between the doctor and patient played a role in quieting the immediate symptoms.

However, in most cases, another phase of the treatment consisted in bringing the traumatic experience back to consciousness. The emotional cartharsis and reliving was obtained by the use of hypnosis and on occasion with sodium pentothal. An essential aspect of the therapeutic procedure was the subsequent discussion in detail with the patient of the material which had been brought out under hypnosis. The acceptance and mastery by the ego of the traumatic experiences were a fundamental part of the therapy.

The whole atmosphere of the wards was one of expectant recovery. It was taken for granted that the patient would get well, and be able to return to duty. The effects of recovery all around the patient are as contagious as panic may be. Group psychotherapy aimed at getting the soldiers to discuss details of their experience, to realize that these were universal and not unique. Patients were urged to talk with each other and to compare notes. The purpose was to enable them to look at the situations realistically; to evaluate the actual dangers, stripped of the tremendous overemphasis of phantasy.

As soon as the patient was able to get up, which was usually within twenty-four hours, he was encouraged to participate in ward and group activities. The patients policed their own wards, acted as ward attendants, litter bearers, pitched tents, dug fox holes, ditched and performed innumerable other necessary tasks. This was all on a voluntary basis, and was presented to the soldier as doing something for the other fellow or for the hospital. Recreational activities, movies in the recreation tent, Red Cross, shows, sing-songs, were encouraged and participated in by the patients.

As the patient improved, the desire to return to duty, to help his buddies, unit, and country, began to come to the surface. Many patients soon asked to return. In some instances a certain amount of bravado was present, and the soldier had to be tactfully told to wait for another day or so. The wish for duty rather than the "kick to duty" was the important thing.

The psychiatrists lived in the wards for the agitated and sicker patients. Their presence was a definite reassurance of therapeutic value. During air raids, artillery fire and the alarums and excursions of war, panic was prevented. Hot cocoa or coffee was available at night. The ward patients gathered around in a sort of discussion group. Even though they were disturbed by guns and other noises, the air of relative calm that prevailed diminished their sense of danger. No one pretended to be a hero. Fears were frankly discussed on a realistic level. Humor at the appropriate moment also helped.

The ward attendants in the hospital soon related themselves to the atmosphere and were of tremendous help in carrying out the program. It is difficult to discuss an atmosphere, but enough has been reported to indicate the direction of the attempt. The evacuation of patients with minor illnesses or wounds or combat fatigue in itself served the purpose of adding value to illness. The greater the number evacuated, the greater the number who seek evacuation. The matter of fact acceptance of the premise that the patient would recover and return to duty, that combat fatigue in itself was not a cause for evacuation from the island, reversed this tendency. All treatment programs should have been oriented to the psychological significance of early evacuation of large numbers of soldiers.

From a long term point of view one did not always do a soldier a favor by evacuating him from the combat zones. To counter the gain there were feelings of guilt and a need for constant justification for having run out "without any wound" or organic illness to show as the "Red Badge of Courage." The loss of self-respect was also a factor that made for the necessity to continue neurotic symptoms into civilian life in many instances.

In terms of the future of the individual, the gain in self-respect at being able to overcome the neurotic difficulties and to return to combat or duty was of inestimable value. There was pride in being able to say, "I went through such and such a campaign" rather than, "I had to be evacuated." On the other hand, it was important that the soldier feel that if necessary, all the facilities at his country's disposal would be made available to take him to that place where he would receive the best care possible.

Rest Camps

The influx of patients presented a problem in bed space. It was also necessary to have facilities for those soldiers being returned to duty who needed several more days of recuperation in a non-hospital environment. To meet this need, a divisional rest camp for combat fatigue cases was set up by one division. These soldiers were on a duty status. This was an excellently planned rehabilitation program; the equipment capacity was for seventy-five soldiers, and it was planned to increase this number later. Lieutenant Colonel Byron B. Cochrane, Division Surgeon, outlined the plan which was accepted and put into effect by the Commanding General, Infantry Division.

Another Infantry Division also set up a similar camp for a limited number of soldiers. Both of these camps were operating successfully during the latter part of April 1945. The Corps instituted a similar rest camp, with a capacity of seventy-five soldiers. A trained psychiatrist devoted part of each day to this camp.

The bed space saved, the excellent effect on the soldiers, made these camps an extremely valuable adjunct to the psychiatric program. One value of the divisional rest camp was that it enabled the soldier to maintain his identification with his unit, especially since he was placed on a duty status.

Reassignment as a Therapeutic Means

One of the most difficult problems that had to be faced was that of the soldier who was not ready to return to full duty, yet who could perform some valuable duty within the divisional area. There were two types of such cases; the first included a large group of soldiers who needed several weeks of relatively rear echelon duty before being able to return to full combat duty. The other was the group who could give valuable service elsewhere than in their previous front line assignments. Realization that there was a relatively limited number of such assignments kept recommendations to a minimum. Nevertheless, the value in the morale, importance of non-evacuation, and the maintenance of the soldier's self-respect made it essential that such reassignments, either temporary or permanent,

be made available. In this operation, the excellent cooperation, especially of the Commanding General of one division and Personnel, allowed for a number of such reassignments. One of the few reoccurrences reported was in a soldier for whom the psychiatrist had definitely recommended reassignment, with the note that he was unsuitable for front line duty. When, on his return to his unit, he was immediately sent into combat, he appeared at the hospital in a few hours with the return of his symptoms. It was recommended that provision be made for reassignment upon competent medical recommendation for divisional duty of certain selected soldiers.

Incidence

During the first month of combat 15.01% of all admissions were for neuropsychiatric reasons. The ratio of neuropsychiatric cases for those wounded in action was as 1:4.16. There were a number of factors in the production of these casualties. First and foremost, the heavy concentration of enemy artillery fire, which was faced by most of the soldiers for the first time in the Pacific, bore the heaviest responsibility. One could tell from the admissions which company or which battalion had been subjected to heavy fire by the number of neuropsychiatric casualities admitted from these companies. The soldiers feared the artillery most, and constantly talked about it. During the course of the treatment, many of the traumatic incidents centered about this. Prominent were stories of intense firing which caused heavy casualties, killed and wounded buddies, "old" men, decimated units, and being blown out of fox holes one or more times.

On the other hand, Major General Arnold, Commanding General of an Infantry Division, reported that one unit, well dug in, received 2,500 rounds of Japanese artillery fire during one night without a single neuropsychiatric case. This observation seems of great practical value since apparently the soldier securely dug in shows much less of a tendency to react with combat fatigue. The effect of being caught in friendly artillery fire seemed to produce even more intense reaction. There are a number of psychological explanations for this. The 320 mm. mortar fire also precipitated a fairly large number of cases.

The survivors of units that had become isolated, pinned down, and had had a large number of casualties, showed a high incidence of combat fatigue. Another factor was the length of time that an outfit was on the line without relief. Many soldiers complained bitterly about such situations. They felt that somehow relief should come, regardless of the reality of the situation.

Many of the soldiers felt that they had been in too many campaigns, that they had reached the limit of physical and mental endurance. In relation to this, an attempt was made to ascertain the proportion of replacements

who broke down to the number of seasoned soldiers. It was not possible to obtain accurate figures. It was evident that both replacements and men who had been through many campaigns needed to be hospitalized. Some of the more severe cases were among ranking non-commissioned officers. It was observed that a sense of intense guilt over leading men who were killed or badly wounded seemed to be a prominent feature. This was also true of officers. There was often a marked loss of self confidence and self assurance since they felt that if they had been "better men" or "good leaders" they would not have had so many casualties. The relatively short time between operations also seemed a factor.

Physical exhaustion played a role, but apparently was not as significant here as has been reported from other operations. Morale was important. Attitudes towards officers, such as lack of confidence, hostilities, reaction to new officers who were deemed inexperienced, were among the precipitating causes. The attitude of command has been shown to be of importance in many respects. It is perhaps of some significance that the figures from a hospital indicated that one unit in a division accounted for 70% of all psychiatric cases coming from that division. It was, of course, not possible to evaluate the relative intensity of combat for all the RCTs in this division, but the percentage seems out of proportion.

Cases that were sent to the field hospitals were selected only to a certain degree. In spite of the intention of sending only the most severe ones and those intended for evacuation, the pressure of cases resulted in sending to the rear many milder cases frequently within an hour of admission to the clearing company. The percentage in the field hospitals of psychiatric cases to all admissions was 12.8%. On certain days the percentage of admission ran as high as 25% to 30%.

Results of Treatment

As a general rule, statistical data that are obtainable during active combat are not of any great value, especially in regard to therapeutic effectiveness with psychiatric patients. There are many variables that have to be taken into account so that a mere report in terms of percentages returned to duty never tells the actual story. It is essential that the total situation be known. For instance, the length of combat is directly related to the recurrence rate. A campaign which lasts five days may show a high return to duty with a low recurrence rate, whereas a longer campaign may show a low return to duty rate and a high recurrence rate. The type of combat, the attitude towards the returnee, and the type of assignment among others, are all features which have to be considered. It is, therefore, with a great deal of tentativeness that the following is submitted.

During the first month of combat it was difficult to evaluate fully the

results of treatment. For instances, at times it became necessary to evacuate all patients— medical, surgical and psychiatric, regardless of condition, because of lack of bed space, blankets and tentage. It was during this period that a hospital was forced to move its location because it became flooded, and it was necessary to evacuate 193 psychiatric cases on one day. These patients were put on LSTs and hospital ships and sent to the rear.

It was realized that there would be a certain overflow of psychiatric cases and a leakage in evacuation due to numerous unforeseen factors during combat. In anticipation of this event, the office of the Surgeon, POA, requested that a field hospital earmarked for this theatre be allowed to substitute five psychiatrists for other members of the staff. The hospital was then assigned to Saipan to function as a treatment center for acute cases not only from combat but also for treatable cases in the Marianas.

In 252 cases diagnosed as 'combat fatigue' or psychoneurosis which were treated in one field hospital, approximately 90% were returned to divisional duty, 56.8% being returned directly to full combat duty. The majority of the others were recommended for temporary reassignment with the expectation that they would be returned to full combat duty within fourteen days. A small number of cases recovered from combat fatigue, but were transferred to medicine and surgery for minor illnesses and were subsequently to return to duty. It should again be emphasized that statistical evidence as such may not be of particular value. An endeavor, however, was made to return to duty only soldiers who showed promise of being effective.

There were approximately 1500 patients with psychiatric disorders seen at the various echelons. The percentage returned to divisional duty was somewhere between 85 and 90.

An attempt was made to check on reoccurrences. We obtained a list of only eight such cases. However, it is quite certain that this number was actually much too low.

There were a number of psychotics, schizophrenic and manic depressive psychoses, a few cases of blast concussion, and some neurological cases, that were evacuated to the rear areas.

Some of the severe combat fatigue cases were evacuated, with the expectation that they would be able to perform duty in the rear area. A subsequent check in the Marianas revealed that many cases were being returned to such duty. It was not possible at this time to find out how many of these were from the group of 193 patients that had been evacuated for the lack of bed space. In the early part of the campaign there was some loss through evacuation, since patients were sent directly from the clearing company to the holding unit. Approximately 700 or some 50% of the total number of psychiatric cases were treated in the clearing station and other forward

echelons. The vast majority of these patients were returned to duty directly without coming through a field hospital.

It was expected that when accurate figures were obtained, they would show that approximately 80% of the cases, on a conservative estimate, would have been returned to effective divisional duty, rather than the present indicated 90%. Although this report covers approximately twenty-five combat days it was too early in the campaign to be certain as to the number of recurrences that actually took place.

A word of warning is indicated in relation to the possible use of these various techniques in civilian practice. One must realize that in the military situation, especially during combat, one deals with a special atmosphere and a type of problems not usually present in civilian life.

There were an exceedingly small number of officer patients with primary psychiatric symptoms. The exact figures were unobtainable.

In order to demonstrate the type of clinical problems encountered, certain illustrative cases are included. It is also intended to show typical problems in disposition.

The first case is that of a first sergeant who had had a good deal of service and campaigning. The great sense of responsibility for his men and the guilt over their death were characteristic.

Case 1

Twenty-nine years old, white male, C. E. Infantry. Four years service, three years overseas, four campaigns. He came in in a state of complete panic, confused, crying, disoriented, thrashing around on the litter. The story was that he had been caught in a concentration of mortar shells. He was immediately hypnotized and allowed to abreact. The important aspects of his story were his fear and his refusal to admit it because of his dread of being thought yellow, his feeling of responsibility for his men, 45 of whom had been wounded, and his superficial loyalty to his officers. However, when pressed on the latter point a great deal of hostility was found to those officers. He blamed both them and himself, and there was a curious and confusing identification of himself with his officers.

After abreaction under hypnosis and a good sleep, he improved markedly. His marked tremor disappeared, and he insisted that he was entirely well. His problems were talked through with him on several occasions, and he took a leading part in some group therapy discussions. His guilt remained, and it was undoubtedly that guilt which drove him back to duty. He felt he must atone for the deaths of the 45 men, that he must expiate by his own sacrifice.

He was returned to duty. He was certainly far from a well man, but we considered that the chance was worth taking. No deeper personality exploration was done; in fact it was considered dangerous, because of the severe nature of the guilt feeling.

Diagnosis: *Combat anxiety state, severe.*

Disposition: Return to full field duty, combat.

The next case demonstrates a problem which often confronts one when dealing with an officer. The lack of self-confidence engenders the break-down, which in turn may add to the sense of insufficiency. The question of returning such an officer to his own outfit has to be answered on an individual basis, but in many instances it is better to make a reassignment.

Case 2

This patient entered the hospital with a diagnosis of battle exhaustion. His history revealed that he had a fit of uncontrollable crying and tremulousness after being exposed to intense artillery fire. The history also indicated that he had had previous symptoms which were traced to emotional difficulties, and he was under observation by the psychiatrist at a General Hospital for headaches and stomach trouble of psychological origin. He had dreaded approaching combat, wondering if he would measure up to his own expectations of himself. From all of these factors the man's break-down could almost have been predicted under the type of psychic trauma to which he was subjected.

This officer very quickly regained his composure and showed no overt anxiety. He had excellent insight into his problem. He felt that he could not return to command of his rifle platoon; he felt that he had lost the confidence of his men, that he was guilty, and had fallen down in his responsibility. Finally he was unsure that he could again face artillery fire; he had lost his own combat confidence. However, he was anxious to continue to serve at this base, and felt that he could do duty in Q.M. or Ordnance.

Because of the factors discussed above, and because it was found in the past that officers who have suffered break-down in combat do not function well when returned to their own units, it was recommended that this officer be reassigned within the Division to some job which would not require him to face combat conditions. Such reassignment would retain a useful officer, who otherwise would have to be evacuated.

The third case is one that was seen fairly frequently. In addition to the interesting clinical picture, with a rather spectacular recovery, this soldier showed the almost universal reaction of such cases in his desire to help other patients. His disposition presented no problem inasmuch as he could return to full duty and was anxious to do so. Nevertheless, he might have been of greater value in another type of assignment.

Case 3

This patient came into the hospital on L plus 12 with a diagnosis of severe anxiety hysteria. He had been held for three days in the clearing company where it was noted that he had been semi-stuporous, mute, with acute startle reflexes, continued crying and calling for his buddies. On admission he was still acutely agitated and had to be sedated by hypnosis. The next morning he was the same and continued so until afternoon. At that time he was forced to abreact some of his repressed material, and a great deal of hostility was allowed to come out. At the end of this treatment he was acutely agitated and hostile; in spite of this he was again hypnotized and after a short sleep became quite his normal self. That evening there was

a good deal of bravado about his attitude, and the next day he again became agitated on hearing of the death of a buddy. He was quieted and allowed to talk out more of his difficulties. It was found that his basic conflict material had to do with his relations to authority, and that his initial crack up occurred after an officer, of whom he was very fond, had been killed.

The patient was given further intensive therapy and maintained his improvement. He had formed a very close positive transference relationship to the psychiatrist, and had become very interested in battle fatigue states. He was invaluable in the care of agitated patients.

The patient seemed completely recovered from his combat neurosis. He had been with his Division in all of its overseas campaigns, and he had some of the hopelessness which such long service engendered. However, he was willing to return to full duty, and was able to do so. It had been our impression, however, that his very definite aptitude for combat psychiatric work was so great that it would be a definite gain to the Army if he were utilized in such work, and he was returned at this time with the suggestion that he be sent to the Clearing Company to work with psychiatric casualties. If this could not be done, he could be returned to his outfit. This was all explained to him, and a letter written to explain the unusual features of this case. He served as assistant to the psychiatrist in the Clearing Company and then requested reassignment to his combat outfit, which was granted.

The fourth case presents the problem of the soldier who perhaps should never have been allowed to become a member of a combat organization. He typifies a fair number of such individuals where the break-down is almost predictable in advance. He also shows the type of case that is evacuated, not because of his combat fatigue, but because of his underlying personality inadequacies.

Case 4

This 37 year old soldier was admitted on L plus 14. On admission he was acutely agitated and fearful, crying, tremulous, in a terrific panic. The first night in the ward he had to be quieted by hypnosis, after which he slept well, in spite of an air raid. With rest his acute anxiety cleared up, and he stated that he felt as he did before the acute anxiety attack, which was caused, he said, by being caught in heavy artillery fire. He thought part of his trouble was his thoughts of home while he was under the barrage.

In the hospital he complained greatly of his back. This trouble started when he was 18, though he remembers no trauma. He was hospitalized for 9 months at age 21 for this. On examination one found lumbar spasm, lumbar scoliosis, and congenital shortness of the right leg. His knee jerks were very brisk, his ankle jerks less so. There was some hypesthesia and hypalgesia of the medial surface of each foot. The neurological examination revealed no other indications of a possible herniated disc, but he did give a story of recurrent attacks of back pain, with numbness and aching in both legs. That there was a psychogenic element was indicated by the fact that his posture was completely camptocormic, but that he was easily made to walk upright by suggestion.

His whole past history was that of an inadequate personality. He was

small, slight. His mental level was obviously low. For example he could not give much of a history of his Army training. He had finished only 6 grades in school, and had had to repeat grades. His work history was poor. On the serial 7 test he answered: 98–85–76–65–55–48–39–32–25–18–12–6. No intelligence testing materials were available. He said that he had trouble understanding orders in the Army, had trouble learning in basic training. On top of all this, he has been easily frightened and excited all his life. He was 37, married, with four children, one of whom was in the Navy. He did not know why he was drafted. He had a hemorrhoidectomy in 1944, and another in March 1945. These, he said, made his back worse. He also had pruritus ani.

This man was neurotic, inadequate, and may have had true orthopedic disease as well. He was not evacuated for his acute battle reaction, from which he had recovered, but for his other difficulties. It was felt he would be able to perform simple tasks at some rear base. He certainly was not an infantryman.

Patients who showed marked psychotic patterns of behavior were evacuated. In most instances such patients were sent back to the United States for eventual discharge from the service.

Summary

1. This is a professional report on the functioning of a previously planned treatment program for psychiatric patients in combat.

2. The organization of the treatment echelons is reported.

3. The basic concepts leading to the treatment program are indicated.

4. Details of the type of treatment of psychiatric cases at various echelons are reported. The emphasis at the field hospital level was primarily on rest, individual psychotherapy such as reassurance, emotional catharsis and especially the use of hypnosis for sedation and catharsis; group psychotherapy, recreational activity, ward organization, a work program and rest camps.

5. The incidence of neuropsychiatric cases with some of the precipitating factors are discussed.

6. The results of treatment are indicated.

NEUROSES OCCURRING IN SOLDIERS AFTER PROLONGED COMBAT EXPOSURE*

By ALFRED O. LUDWIG, M.D.†

During the Italian campaign a special type of psychiatric disorder was observed in soldiers who had had long exposure to combat. In the early phases of the campaign this type of disturbance seemed to be limited to the higher ranking non-commissioned grades. In consequence, the term "Old Sergeant Syndrome" came into use. Further experience proved that this syndrome could occur among all ranks and grades and later observers suggested the name "Reactive Depression of Old Soldiers" as more accurate. There is no reason to believe that the disorder was not observed in every other theater where troops were exposed to combat danger for long periods.

Characteristically, this clinical picture was seen in infantry soldiers who had served commendably in battle for extremely long periods. By this is meant from six to fourteen months of exposure to enemy artillery fire. Combat time in this sense is limited to that period during which the soldier was in danger, exclusive of rest periods, hospitalization, or other time spent out of the line.

It was typical for these cases to be referred by their officers with letters of this sort:

30 March 1945

Sergeant Blank has been assigned to this Tank Battalion since 19 March 1942 and has rendered valuable service in the Sicilian, Italian and the present campaign (Southern France). He has been wounded once. He has accepted willingly any assignment and has always made a sincere effort to discharge same satisfactorily. During the past three months, Sergeant Blank has become very nervous and unable to control himself and properly discharge his duties when confronted with a combat emergency. His crew members have lost confidence in him and do not desire that he continue as their tank commander. At times he has been forced to use alcohol to carry on under difficult conditions. Sergeant Blank has never, and has not now, requested that he be relieved of his duties or given an easier assignment. However, it is the opinion of Sergeant Blank's commanding officer and the battalion surgeon that this man should not continue in a combat assignment. Request consideration of reclassification and assignment to non-combat organization.

Similar letters were received in many hundreds of these cases.

The usual history was as follows: From two to six months before admis-

* Read before the Section of Neurology and Psychiatry of The New York Academy of Medicine, May 14, 1946.

† Boston, Mass.

sion these patients had noted the onset of abnormal anxiety in battle. Usually this was related by them to some specific event, a difficult attack or river crossing, or more often some personal experience such as the death or wounding of a buddy or a leader, a close escape from death, or return to combat after hospitalization for a wound or illness. From then on anxiety increased progressively. Patients expressed this as: "Each hill was harder and harder for me to take," "I had to push myself harder to keep going," and the like. Apparently greater and greater effort was required to suppress anxiety.

With increasing insecurity and tension came premonitions of certain death, often verbalized as: "My number is up," "Doc, I'm fighting the law of averages," or "Each shell is meant for me." It is important to note that many of these patients reported that they were the last or one of the last remaining survivors of a certain combat group which had come overseas together.

All feared losing control in front of their men. They felt tired, discouraged, empty, alone, helpless and guilty. Sometimes, as has been mentioned, they resorted to alcohol as the only means of controlling anxiety. Not infrequently the non-commissioned officers of this group asked to be relieved of their rank rather than to attempt to lead men in the presence of their own insecurity and anxiety. Such requests were often granted.

On admission to Army Psychiatric Treatment Centers, these patients showed little dramatic symptomatology. Outstanding features were physical and emotional exhaustion and apathy. Their faces were dull and expressionless; they answered questions in a toneless voice and in monosyllables. Tremor was occasionally present. Startle reactions and gross noise sensitivity were either absent or well controlled. On the wards they tended to stay by themselves and often sat on their beds staring into space. They shunned conversation and wished to be alone. They were inclined to be somewhat intolerant of uncontrolled outbursts in other patients.

On interview they were almost universally respectful and well disciplined. Good conscious control of symptoms was very evident. Apathy, emptiness and lack of interest were most striking features in the clinical picture. The presence of anxiety was made apparent by tremor, tension, increased sweating, restlessness and by a history of battle dreams, occasionally involving dead buddies. Usually the only display of emotion they allowed themselves came when they were told that they would not return to combat again. Such a statement was almost always followed by a short outburst of weeping for which they immediately apologized. Depression was

present to some degree in all. Occasionally these patients expressed resentment against officers, usually against those in the higher ranks and not those who had been in direct personal contact with them. All of these men expressed marked feelings of guilt over having left the group and felt that they had "let their buddies down." If told to return to combat, they did so without complaint or protest, only to return again in a few days with more severe anxiety symptoms.

Therapy for this group of patients included the provision of adequate shelter, warmth, change of clothing, bathing facilities, food and rest. Heavy sedation was used at first in Italy, but was later abandoned when it was found to offer little or nothing of value in the treatment of these or other cases. Personal interviews were held with each patient, and in these he was encouraged to tell his story freely, allowed to ventilate resentments, guilt, and mourning reactions. Attempts were always made to understand dynamics and explain symptom formation. It was our routine practice to praise combat performance and to attempt to assuage guilt by reviewing the specific situations in which he had felt culpable. Frequently, these involved abandoning a buddy or the group.

Perhaps as part of their guilt reaction, almost all these men feared they were incurable or that they were or would become insane. In consequence, the meaning of the diagnostic terms, which they would be certain to see on medical tags, as well as the true nature of their disturbance, its probable course and prognosis were explained to them. They were all eager to work and were told that employment in some regular, but non-combat assignment was the best means of overcoming their symptoms, even though these might persist for some months. Needless to say, these therapeutic interviews had of necessity to be brief and in many respects fell far short of the ideal.

The vast majority of these special cases were evacuated to the rear with the recommendation that they be reassigned to non-combat units. They required little further hospitalization and, after reclassification for limited duty, were sent promptly to Replacement Depots for reassignment. A follow-up study of fifty patients with over six months of combat exposure and who were sent to the rear from Seventh Army Psychiatric installations showed that ninety-four per cent were performing satisfactorily or better in their new assignment from three to six months after leaving Army hospitals. Residual symptoms were present in many.[1] This information was obtained by letter from the commanding officers of their units. These results are neither better nor worse than those of the entire group sent to the rear, regardless of the length of time spent in combat before admission.

Etiology and Psychodynamics

What factors contributed to the breakdown of these excellent soldiers? It is difficult to divide precipitating or causative factors into external and internal stresses. These must always act together and must be closely related. During the Italian campaign psychiatrists raised the question; "What made these men stay in combat?" rather than; "Why did they break?" The group under discussion furnished a good source for such information. They were asked routinely what had helped keep them effective in combat. Their answers were direct and simple; "It was my duty," "Somebody had to do it," "I could not let my buddies down," "How could I expect my men to carry on if I could not control myself?". Thus the personal pride and group loyalty of the soldier seemed to be the most common conscious sustaining factors. Ordinarily, ideologic or patriotic motives for fighting were not mentioned.

Any consideration of dynamic factors must include some discussion of the group as a supporting influence to the individual in combat. There is ample proof of the importance of the group as a morale factor in battle. For the soldier the immediate group around him in combat (the squad or platoon) held the greatest meaning.

The individual soldier's safety and his life depended upon the physical integrity of his combat group, upon the competence both of its members and of the group as a whole. To fail the group in one's duty meant that each individual endangered himself as well as every other member of it. The soldier probably transferred to individuals in this small group all of his important emotional attachments. There was the closest identification with the group. Each soldier felt himself a part of it and in turn felt the group as part of him.

The fact that most soldiers separated from their combat group wished to return again to it is strong evidence of its value. Hospitalized wounded routinely wished to rejoin their original unit. Before this was generally understood and made routine policy, it was not unusual to find men becoming absent without leave from hospitals in order to rejoin their units, rather than to chance being sent to a strange one. Conversely, those who were not permanently assigned to a group, such as replacements in depots, felt keenly the lack of support therefrom. One man expressed this beautifully: "Being a replacement is like being an orphan, you are away from anybody you know and you feel lost and lonesome." The analogy to the family is evident. Group spirit influenced the incidence of desertion. Men were more likely to become absent without leave when separated from their group and also when they belonged to groups with low morale.

The group leader was the key to the integrity of the group. The efficiency and strength of the group and of its individual members depended largely upon him. The good leader provided a strong object with which to identify and was then looked upon as a relatively benevolent and protective authority in a hostile environment. Such a leader had to possess a high degree of technical ability and had constantly to look after, support, protect and spare his men insofar as that was possible.

The poor leader was disruptive of both individual and group morale. He aroused great hostility, not only against himself, but against all other authority in turn. In such cases, the only possible identification left for the combat infantryman was with his counterpart on the enemy side. There was no one else so completely thrown by his authority to the mercy of the deadly environment. In the opinion of the author, the motivation of the American soldier in Italy and Southern France was closely related to the quality and beliefs of their leaders, especially their immediate junior officers. Their ideals and behavior were mirrored in their men, whose morale was greatly influenced by that of their officers. In the opinion of these patients, leadership in general was good.

Leadership varied with the division. In some, good direction was traditional and was nurtured from the Commanding General down to the youngest lieutenant. In one such division, this resulted in a consistently low psychiatric casualty rate, in spite of the fact that the division sustained one of the highest battle casualty rates of any in the Army in this war.

Unfortunately, attachments to both the leader and the group could eventually also become weakening influences for the individual by reason of continuing attrition. The death or wounding of a beloved excellent leader was highly traumatic and was often followed by the breakdown of efficient soldiers. With such a loss the group tended to disintegrate and the soldiers felt helpless and alone. Good leaders seemed to be imbued by their men with almost superstitious degrees of omnipotence and ability to protect. Attrition among junior officers was often very high. At one point in Italy the casualty rate for infantry second lieutenants reached five hundred per thousand per month. It was customary for higher ranking non-commissioned ratings to orient new officers as they came to replace casualties in combat. It was not uncommon for these men to tell us that they had "gone through" twelve to fifteen lieutenants in this way over a period of a year or more.

Within the group such a successive loss of leaders and also of buddies eventually weakened each individual's defenses against anxiety. These often failed completely when he found himself one of the last remaining members of an original group. Such losses impoverished the personality

and this was probably at the root of the apathy and emptiness which was so characteristic of these patients. It was as if each loss chipped another piece off the personality until nothing was left. It is interesting that depressive reactions when seen in the combat zone rarely manifested suicidal trends, perhaps because loss and mourning were the primary psychodynamic factors and hostility was usually not prominent.

What other factors operated in producing breakdown? Predisposition has been widely discussed. Those who worked in combat zones with psychiatric casualities were progressively less impressed with the importance of such predispositions. One frequently saw patients who had withstood eight or ten months of combat in spite of a history of severe premilitary neuroticism.

Personal pride was an important sustaining influence. As a morale factor its strength depended on the quality and integrity of the group and its leader. Pride in one's family also played a part. Gross defection of a leader in battle was ruinous for group morale. In one such instance an extremely high psychiatric casualty rate resulted in a unit when its leader, in order to evade further danger, shot and wounded himself in front of his men. Lack of support from the family by letters devaluating or misunderstanding the soldier's war effort or disloyalty of a wife or girl friend back home resulted in loss of personal pride and confidence and the feeling that there was nothing worth fighting for.

Guilt was a prominent feature in all of this particular group of patients. It was common for them to accuse themselves of having let down their buddies. Often this involved not having stayed with a buddy under impossible conditions. Sometimes a panic flight or the impulse to flight were in the foreground. In any event, all such behavior was felt to be seriously hostile against the group. It is probable that this aroused a need for retaliation which contributed to the guilt feelings.

Absence or separation from the group were also weakening influences. Hospitalization for minor wounds or illness was mentioned as a precipitating cause by patients in whom breakdown had occurred upon return to combat. Here separation from the group was disrupting. In addition, the long hospitalization gave ample time for highly traumatic fantasy formation.

In Italy as well as in Southern France, necessity dictated that troops be kept on the line without relief for long periods. Perforce this added to the soldier's feeling of hopelessness and despair and weakened his will to go on. It was readily observable to him that only death or a wound could give respite. "Old" men (with seven or more months of combat) in contradistinction to "new" men (with less than three months combat)

found combat increasingly frightening and often admitted that they hoped for a wound in order to have an honorable reason for leaving battle. They also had less confidence in their officers, were less likely to believe that headquarters understood their problems and needs and were less inclined to believe that they were getting a square deal in the Army.

It is difficult to estimate to what degree such attitudes were the result of the impact of reality in combat, with constant exposure to death or mutilation, successive loss of friends and the knowledge that relief would probably come only with death or with a severe wound or to what extent they were manifestations secondary to gradually weakening defenses against anxiety.

Political or ideational motivation was not found in American soldiers in Europe or Italy, certainly not among psychiatric casualties nor probably in most others. Few fought for a positive cause, or even against fascism. Few knew the real meaning of fascism or what it had done in Europe. It was illuminating to overhear the statement of American soldiers viewing the evidence of mass murder and persecution at the Dachau Concentration Camp a day after its liberation: "This is the first time I've known what this war was about."

Primarily these men fought to go home and for their buddies and leaders. It is highly probable that much could have been done to improve the motivation or even the orientation and information of our troops in Italy and Europe. Further exploitation of this field might have provided some counterbalance to the almost inevitable disruption secondary to attrition within the group and would have given these men something over and above those furnished by vulnerable group identifications.

In therapy, the positive strength of group identifications was utilized by reintegrating these men into new groups as rapidly as possible. In so far as possible, symptoms were removed first. One tried to relieve guilt by explanation, reassurance and by the provision of opportunity to continue to help their buddies at the front in some tangible manner, even though this was no longer in combat. In retrospect, more might have been done to uncover and understand the fantasy formation in these patients. It is doubtful, however, if any further therapy of the emergency type possible in forward areas could have restored combat efficiency to this group of apathetic and depressed soldiers.

Reintegration into a new group would appear to have been rational in that it allowed for new object identification. The success of the method, in restoring emotional health, can only be determined by follow-up of a group of such cases at this time. It is known that they could serve effectively in non-combat jobs for long periods. However, many had residual symptoms when followed up six months later.[1]

Prevention

The vital importance of motivation as a factor in prevention must be strongly emphasized. This implies the development in every soldier of individual moral sense and of group pride. Each soldier must have a meaningful understanding of and conviction in the cause for which he fights as well as a positive appreciation of the values of democracy. Motivation and indoctrination must utilize emotional as well as intellectual channels in order to accomplish this. The psychology of motivation needs intensive study before it can be properly understood. Such studies should be pursued vigorously lest the grave weakness of improper motivation so apparent during this war be further perpetuated in the Army during its important task of occupying and re-educating defeated enemy countries.

Good leadership is of supreme importance in the prevention of psychiatric casualities. The improvement of leadership in the Army involves far-reaching concepts. A better understanding and clearer definition of what constitutes leadership is the first requisite. Improvement of selection methods must follow and should include careful psychiatric evaluation of each officer candidate before acceptance. After commissioning, each officer should be thoroughly indoctrinated as to the importance of leadership and the grave responsibility which he must assume with his rank.

If the discouragement secondary to inordinately long tours of combat duty is to be avoided, satisfactory methods of rotation and rest for infantry troops must be devised. Practices current in this war, even though tactically unavoidable, led to lowering of morale. In consequence, men developed the attitude that they were given less consideration than materiel. The impersonality of modern war with its inevitable emphasis on the machine makes it essential that the individual soldier be given constant proof that his officers and the high command are interested in him as a person. Otherwise, he feels utterly lost and helpless and may become highly vulnerable to emotional break-down.

The psycho-dynamics of the disturbance described in this paper have focused attention upon the importance of the group in preserving morale. The strengthening of group solidarity is a vital preventive measure. It is possible that many of the men who broke in the manner described might have been salvaged for further combat if they could have been relieved from combat and reintegrated into new small units before the personality had been too greatly weakened by continuing attrition.

The replacement system needs revision to provide greater regard for the replacement as a person. It is likely that new replacements could be more adequately protected against break-down if they were to be trained, shipped and allowed to enter combat as groups, rather than as individuals. While the policies prevailing during this war were highly efficient in main-

taining numerical strength of fighting units, morale of both the remaining survivors, who fought on and on, as well as of the new replacements suffered because of continuing disruption of group solidarity from heavy casualties. There is some evidence that gradual introduction of the individual replacement into combat decreases the incidence of psychiatric casualties. Heavy action upon first entering combat is highly traumatic and results in a higher rate of breakdown in new soldiers, perhaps because group identification has not yet had time to become effective.

Summary

Among divisions with extremely long combat experience in Italy and Southern France, psychiatric breakdown occurred in a large number of very efficient soldiers after they had been subjected to danger with little relief for from six to fourteen months.

This disorder, popularly known as "The Old Sergeant Syndrome" was frequent in non-commissioned officers but occurred among all ranks and grades. It was characterized by a slow progression of anxiety over a period of months, culminating in a break. Outstanding features in the clinical picture were apathy, depression and emptiness, superimposed on the usual anxiety symptoms. Guilt feeling was prominent in all. Suicidal trends were very rare.

In addition to usual psychodynamic factors it is believed that the successive loss of identified objects due to heavy attrition within small combat groups played an important role in etiology.

Therapy aimed to explain symptom formation, allay guilt and rapidly to reintegrate these men into new groups in non-combat units. Here ninety-four per cent performed satisfactorily. Means of preventing such casualties are discussed.

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PROGNOSIS IN ACUTE COMBAT NEUROSES*

By JOSEPH W. OWEN, M.D. †

It would seem too early at this point to draw any general conclusions regarding the prognosis of combat developed neurosis. They must await years of observation under a variety of stresses. I have available, however, some data on the outcome of a group of cases treated intensively by Drs. Tillman, Bruner and myself in a forward area hospital in the Solomon Islands, who were returned to full duty in that area. How they fared until the end of the war some nine to twelve months later might serve as a beginning study in the evaluation of treatment.

Although we treated some 1000 psychiatric patients in this general hospital in the course of its 14 months of activity, we selected as a group for study 146 psychiatric casualties—the *total* casualties sent *directly* to us by ship from the combat areas without passing through other hospitals en route. They came from Saipan, Guam, and Peleliu, some 1500 to 1800 miles away, arriving on an average of about five or six days after evacuation.

The prognosis of combat casualties in general must be determined by evaluating the personality, the stresses, the severity and types of reactions as well as the type of treatment used. Since the personnel of the three groups consisted almost entirely of seasoned enlisted Marines, and the campaigns they were in were all severely contested, these groups might seem to be favorable for a comparison of the effects of treatment.

When this general hospital was set up in the Solomon Islands in the spring of 1943, there was very little data available in the literature or in personal experience regarding treatment of psychiatric casualties in such a forward area. In general, the procedures recommended seemed to have been varieties of sedation, rest, and such psychiatric interviews and adjunct procedures as time and circumstances permitted. It was necessary, therefore, to do some experimentation to determine the most practical and effec-

* Read at the section of Psychiatry of the New York Academy of Medicine May 12, 1946. This is a follow-up and elaboration upon a previously published paper entitled "Treatment of Combat Fatigue at a Forward Area Hospital" by Joseph W. Owen, Comdr. (MC) U.S.N.R., Carl C. E. Tillman, Lt. (MC) U.S.N.R., Richard A. Bruner, Lt. (MC) U.S.N.R. in the Naval Medical Bulletin, 45:611, 1945, based upon further data now made available for publication. The opinions and statements advanced herein are those of the author and are not necessarily to be regarded as those of the Navy Department.

† 550 Park Ave., New York City.

tive methods of treatment. We had decided that our efforts for practical purposes should be directed towards the more acute combat induced neuroses who had shown relatively stable personalities before combat. The others were to be evacuated as promptly as possible to the rear areas.

The first small group of psychiatric cases from Saipan, a total of 26, were treated intensively. The individual psychiatric interviews were used as the basis of treatment but, in addition, other psychiatric measures were experimented with such as group psychotherapy, hypnosis, varieties of sedation including cold sheet packs, sub-shock insulin, measures for building up appetites and weight, recreational activities, narcosynthesis, etc. The results of these various measures were not very encouraging. Only 43% of these acute combat neuroses (27% of the total psychiatric casualties) improved sufficiently to be returned to duty and most of these under some protest. In general, it may be said of this group on admission that their attitude was that they had done their duty, they were fed up with the war, felt sick and discouraged, and thought they deserved to be home. Their original allegiance to, and identification with their group appeared completely broken. After treatment of quite intensive variety, using the measures stated, their attitude had changed relatively little, and their various symptoms had improved only moderately. Ward rounds were rather depressing. Patients complained of headaches, weakness, tremor, sleeplessness, tension, and a variety of hypochondriacal complaints and there was a general attitude of dissatisfaction, in spite of the large amount of attention paid them, and it seemed as if they felt they were merely being "fattened for the kill." This same experience has been observed frequently in hospitals in this and other regions and had resulted in considerable discouragement regarding the possibilities of ever returning these men to duty.

However, there were certain lessons that came out of this group. In the group psychotherapy sessions as well as in individual interviews, these men expressed the feeling that they had failed. They had failed their comrades, they were failures as Marines, they did not want to go back because their comrades did not want them and they showed a strong desire to return to earlier protective situations. A member of a combat team such as a machine gun unit, could not have one of its members undependable, as he would endanger the whole group. Though over-determined, these were reality problems and the various psychotherapeutic procedures, explanation and assurances from the doctor proved of little avail. As so frequently happens in military hospitals, we had insufficient segregation of the potentially recoverable cases. Some severe combat neuroses were kept on the ward with mild ones. A few chronic psychoneurotics and a psychopath or two were left on the ward to the detriment of ward morale. The men had a tendency to lie around in the beds in the foetal position and many did not

know until the last minute what was going to happen to them since decisions regarding their disposition awaited observation of effects of treatment. In the next group we planned to remedy these mistakes and primarily to attempt an additional procedure of reintegration into the group.

In the next two groups, Guam and Pelelieu, totalling 120 patients, the general procedure was as follows:

1. The patients were segregated as rapidly as possible so that the recoverable acute combat induced psychoneurotic reactions were all on one ward. One of the psychiatrists gave each man a quick appraisal as he came off the trucks before they entered the neuro-psychiatric service. This appraisal was largely directed towards determining the acuteness of onset, the intensity and nature of the reaction, as well as the degree of improvement en route on the ship. In the next two hours, a physical examination and a history of the present illness was accomplished and the patients reevaluated and shifted immediately if necessary. The chronic psychoneuroses were carefully separated from the acute recoverable combat neuroses. The men usually arrived late in the afternoon or early evening; they were given fruit juices or coffee, 1½ to three grains of nembutal and turned in. The next day was taken up with finishing the psychiatric examinations, laboratory work, consultations, etc., so that by the following morning, *some thirty-six hours later*, the psychiatrist was in a position to evaluate pretty closely the total mental and physical status of each man. What was also of considerable importance was that the men were immediately impressed with the thoroughness, promptness, and amount of attention given to their complaints. The procedure at this time was for the psychiatrist to speak to this "combat fatigue" ward group, telling them he appreciated the fact they had been through hell emotionally and physically, were tired, fed up with the war and so forth and had emotional symptoms resulting. Yet they would soon be well enough to return to duty after a period of rest and relaxation and there was a bit more duty ahead before a well-deserved return to their homes. They were also told that they would stay in the hospital from three to five weeks and that the medical officer would talk over their problems with them during this period. They were told it was hoped that they would have as much relaxation and pleasure as possible while there, that a minimum of required work would be divided among them, but that the rest of the time was their own, subject only to basic military regulations. The problem of treatment of sleep difficulties was explained. Good sleep was important for rest; the medical officer would give them sleeping medicine at times to tide them over, but the way to obtain proper sleep was to take exercise. They were then encouraged to take advantage of a program of activities that had been developed for their pleasure and benefit and these were outlined to them. The *wards would be closed* to all from 8:30 to 11:00 and from 1 to 4.

When the wards were first closed, the men sat around on the ramps and under the trees or lolled around. In a day or so they gradually became interested in the great variety of activities that were going on. Nurses and corpsmen had been instructed to keep these activities going, not to require the men to enter them, to merely attract them. A variety of competitive sports such as baseball, volley ball, basket ball, ping pong, badminton, swimming, punching bags, gardening, etc., were available. A tent had been made into a work shop where masculine activities were encouraged (related to the war as much as possible) such as making souvenirs out of shell cases, useful articles for themselves such as sea chests, watch bands, etc., and making things out of the native hard woods. We were very fortunate in having an active, integrated group of corpsmen and nurses who were interested in this project and their enthusiasm was somewhat contagious. The doctors also entered into the activities.

After a short period, the change in this group of men was quite definite. The morale of the ward increased, complaints decreased and were sometimes minimized by the patients and the wards in general took on a more healthy attitude, at times appearing more of a base for activities than sick quarters.

At the end of four weeks' stay in the hospital, the majority of these patients were symptom free and seemed to have regained their confidence. They felt accepted, capable, and seemed to have proved to themselves that they were as good as ever. Most were willing to return to their units, and their general feeling was that there would be perhaps another period of combat and then they would go home.

This different procedure was used first on the group of 68 patients from Guam, later and better developed on 52 from Pelelieu. As developed, an increasingly larger percent were sent to full duty and more served out their terms. Of the Guam cases, 81% of the acute cases were returned to full duty (62% of the *total* psychiatric casualties received directly by boat from Guam). Of the Pelelieu group, 95% (75% of the total) were returned whereas only 43% (or 27% of the total) had been returned from the earlier experimental group from Saipan (see Table I). This is an increase of almost 50%. Results were also progressively better as far as continuing in full duty status was concerned. A follow-up through health records examined in February 1945 showed that medical data was available on these groups about equally in a total of 86% of those returned to duty. Of these, the following received a non-psychiatric discharge after the war,* some eight to twelve months later:

Saipan	37%
Guam	53%
Pelelieu	93%

A few had readmissions in the field and returned to duty. A few more

* With exception of two discharged before the war on expiration of enlistment.

TABLE I

Total Psychiatric Cases Admitted Directly from Combat Area by Boat to U. S. Naval Mobile Hospital No. 10 in 1944

	SAIPAN	GUAM	PELELIU	TOTAL
Number of psychiatric cases admitted..	26	68	52	146
Number of psychiatric cases diagnosed as combat fatigue (acute combat neurosis).....	16 (61.5%)	52 (76.0%)	41 (80.0%)	109 (74.6%)
Total number of combat fatigue cases sent to full duty directly from this hospital.....	7 (43.8%)	42 (81%)	39 (95.3%)	88 (80.7%)
Total combat fatigue cases sent to rear area hospitals and who returned to full duty later.....	1	0	0	1
Total combat fatigue cases sent to U. S. naval hospitals who were returned later to full duty.....	1	0	0	1
Data on Outcome of Combat Fatigue (Acute Combat Neurosis) Cases Sent to Full Duty				
Number of cases with adequate follow-ups.....	8 (88.8%)	41 (78.0%)	27 (70%)	76 (86.3%)
Of these cases:				
A. Cases that were returned to full duty, had no further admissions to the sick list for psychiatric disorder and were given non-medical discharges after the war*	1 (16.6%)	13 (32%)	23 (85.2%)	37 (48.6%)
B. Cases that were returned to full duty, readmitted in the field, returned to duty in the field, given non-medical discharges after the war.....	1	2	2	5
C. Cases sent to full duty, later given limited duty in the U. S., later given non-medical discharges after the war.....	1	5	0	6
D. Cases sent to full duty, later invalided from the service for medical reasons.....	0	2	0	2
Total combat fatigue cases returned to duty and continued to receive a non-psychiatric discharge after the war*.....	3 (37.5%)	22 (53.6%)	25 (92.6%)	50 (66%)

* Exception: two cases discharged before end of war due to "expiration of enlistment."

were given limited duty in the United States or were invalided for medical reasons after the war. If these were not counted in the statistics (even though they presumably performed useful duty before discharge) those returned that remained in full duty status without further admissions to the sick list and received honorable non-medical discharge after the war were:

Saipan	16%
Guam	32%
Pelelieu	85%

One might add that approximately 11% of the total casualties on these boats were psychiatric and 75% of these were diagnosed as acute combat neuroses, and represented the group selected for this treatment.

We do not know at present how they fared in battle. We received visits from a few who stopped by on their way to Iwo Jima and from these heard indirectly of some dozen more accompanying them. From all accounts these were well and felt confident of themselves. Five were noted in health records to have been wounded in Iwo Jima or Okinawa.

One may say that our process is not new and that these measures in various degrees were used at all psychiatric hospitals. That is true, but we feel it is a matter of degree of attention to each detail and the formation of a well-integrated team geared to therapy. Sometimes the absence of one corpsman who had been a spark plug of energy and enthusiasm or some error causing resentment would show very noticeable decrease in results. Everything must be worked out to the minutest detail to ensure the patient's confidence in the organization and personnel and to develop confidence in themselves.

The following is an attempt to emphasize the salient points in the reintegration part of the therapy:

1. Promptness and thoroughness of physical and psychiatric examination and treatment inspiring confidence in and affection for the physician and organization.

2. Prompt isolation of recoverable cases from the very sick and those disrupting morale.

3. Having the men feel that they were not abandoning, nor had they been abandoned by their units. This was partially aided by the hospital being located close to and almost a part of their base—a jungle hospital.

4. Allowing these men to prove to themselves, by virtue of their capacities as demonstrated in aggressive sports, that they were merely temporarily incapacitated by understandable strains and were as capable as ever of being a member of a successful team.

5. Instilling in this recoverable group that theirs was a privileged group,

and that they were incapacitated temporarily through no fault of their own.

6. Discouraging feelings of dependence and regressive tendencies. A very important step in this seemed to be the closing of the wards for the greater part of the morning and afternoon to discourage bunk loungers; insisting that they eat in the main galley with other patients and keep to the standards of the organization.

7. Close association with corpsmen and well people in their activites; keeping the wards looking as little like sick quarters as possible and generally instilling in the men from the onset that they had mild, entirely recoverable conditions.

8. Giving as few drugs as possible and substituting measures such as exercise that allowed the patients to feel they had overcome their difficulties.

9. Keeping up the feeling that they were individuals, adults capable of respect, moral obligations and affection and capable of successful masculine aggression.

10. Increase of pleasurable activities. Too often it seemed these men were required to do military work as they improved. This might be helpful in some, but in others it caused resentment which might destroy the effects of treatment. It would seem much more advisable to have the men regain confidence in their own abilities through pleasurable activities, and later return to a work schedule.

The other psychiatric measures were quite varied, but the mainstay of all treatment was the individual interview with reassurance, catharsis and explanation. Group psychotherapy as usually used, was not found very useful or practical in this area. Narcosynthesis was useful in a few, but was too time-consuming for this area.

From the observation of these three groups, what conclusions may be drawn? It is my belief that the basis of our treatment was that of ego strengthening, instilling in the men faith in themselves as individuals and adults, strengthening them with the knowledge of their problems, showing that others have respect and affection for them, showing them pleasures and a goal again and giving them a small sample of home that they would prefer to return to with respect for themselves intact after a duty completed. They were members of a successful group again, strengthened in this knowledge that they were just as capable of performing as before.

We are not aware at this time of any specific data in the literature as to how the acute combat neuroses fared after return to duty. Statistics are available however as to the percentages returned to duty. Grinker and Spiegel[1] reported 72% returned to "full or selective duty" of those treated in North Africa using narcosynthesis and psychotherapy and later 81.2% returned to "some form of military duty" from the Air Force Convalescent Hospital in Florida; and Hastings and Wright[2] reported 70% returned to

full duty from the Air Force Hospital in England using prolonged narcosis treatment and psychotherapy. These are approximately the same as our 81% returned to full duty in which group reintegration and psychotherapy was used. Though it is difficult to compare results exactly when the stresses and the original selection of personnel varied so much, it is still valid to conjecture why these results are so similar when the methods advocated superficially seemed so different. Narcosynthesis was emphasized in Grinker and Spiegel's method, prolonged sleep in Hasting and Wright's and reintegration in ours but all carefully used the familiar forms of psychotherapy in conjunction with these measures. In our cases we rarely used any narcosynthesis and never prolonged sleep. Drugs of any kind were avoided like the plague and only rarely was a man given a few small doses of sedatives after admission. Could it not be that the well directed teams and carefully laid out psychotherapeutic programs and very strong suggestive and ego strengthening measures in all were responsible? Though these are used to *some* degree in all military hospitals, the lack of time, of facilities, and the lack of faith in any psychotherapeutic results with these patients have made the known measures of psychotherapy generally very superficially applied. The man isolated from his unit, feeling a failure or rationalizing it, placed in a psychiatric ward with a variety of patients with little to occupy his time, who lay around thinking of home not knowing for a considerable period what was going to happen to him or what did happen to him and who is generally treated rather casually, was an all too familiar sight even in the psychiatric wards of large military hospitals.

As far as the symptomatology of the battle casualities in general was concerned, we were impressed with the fact that there were two main types of reaction. The first was the chronic psychoneurosis familiar in all its types in the civilian life. Then there was a specific type of acute combat neurosis which developed under the dangers of battle with its threats to life and integrity. This latter reaction resembled the acute traumatic neurosis seen in civilian life and was characterized by anxiety, great tension, hyper-irritability and dreams and fantasies in repetition of the combat threats. At times this reaction appeared largely replaced by other psychoneurotic mechanisms such as conversion phenomena, but when these were removed by psychotherapeutic measures the basic reactions seemed to be the same. This acute combat reaction sometimes occurred in patients without previous psychoneurotic manifestations and whose life history could be considered normal, but who had been under great combat stress. The same reaction sometimes appeared in those coincidentally with a long standing psychoneurosis.

The men with previously developed chronic psychoneurosis sometimes

performed well for a considerable period, but generally seemed more susceptible to the development of the additional acute combat neurosis and of maintaining it for a longer period of time. These individuals having previous chronic psychoneuroses generally showed an increase in their old symptoms under battle stress. If one may indulge in speculation, it seemed that in those individuals with a long-standing psychoneurosis the ego had already been weakened by those old conflicts and the additional weakening from the trauma of battle caused both a flare-up of the old problems and a more ready development of an additional new acute combat neurosis. Sometimes old psychoneurotic symptoms were temporarily alleviated by battle probably due to compensatory mechanisms. At other times, specific battle situations appeared to intensify the original conflicts.

The acute combat neurosis, developed in a person with a heretofore relatively strong ego, seemed usually susceptible to proper treatment, and it is our belief that it usually can be sufficiently repaired to make a man capable of further combat duty. Where the ego is markedly weakened by an unusually marked battle trauma, or has been previously weakened by long-standing conflicts, the chances of its repair, sufficient for further full duty, seem remote.

Conclusions: Statistics are presented comparing results of treatment in three small groups of combat personnel. Improvements in psychiatric techniques and measures for reintegration into the group resulted in increasing percentages able to return to full duty and a parallel percentage of these groups remaining on active duty status until honorable discharge after the war nine to twelve months later. Details of treatment are given.

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SOME FACTORS FOUND VALUABLE IN MAINTAINING MORALE ON A SMALL COMBATANT SHIP

By MORTON E. BASSAN, M.D.*

The purpose of this paper is to present the factors that were found effective in maintaining an unusually high level of morale aboard a small combatant ship. It is not intended to discuss all the theoretical aspects of the genesis of morale. For our purpose let us define morale as the will to fight and the maintenance of that will to fight, with a reasonably happy frame of mind, for long periods of time in the face of both danger and deprivation of the usual comforts of life.

Morale is very much the concern of physicians because they, having at their command knowledge of so many of the determinants of human behavior, can be very instrumental in creating the desired mental attitude in the fighting man as well as in the civilian. Morale is very closely related to mental health. It is well established that the number of psychiatric casualties in a military unit depends largely on the morale of that unit. Loss of manpower from psychiatric disorders, therefore, can be kept at a minimum only by controlling the factors which determine morale. One of the combat psychiatrist's chief functions is to advise the command on morale problems.

Two basic factors determining morale are motivation and control of environmental stress. Motivation is the more important of the two. However, no matter how great the motivation, morale will break if there is no emotional relief.

Here we shall discuss some methods which were so effective in alleviating environmental stresses that after twenty-one months of sea duty and eighteen months of actual and constant front line naval warfare duty, the spirit aboard this particular ship was so high that the ship was referred to as the "Queen" of its squadron. No unique methods were used, but, by intelligent and considerate use of materials at hand, quite remarkable results were obtained. In contrast to it was another of the squadron's destroyers on which morale had fallen to such a low ebb that after eighteen months of front line duty all the chiefs, most of the officers and fifty per cent of the crew submitted requests for change of duty or rest and rehabilitation leave.

The ship under consideration is the USS The Sullivans, a 2100-ton destroyer. This ship left the States 2 days before Christmas of 1943, and joined the Fifth Fleet in January 1944 for the invasion of the Marshall Islands. From that date until June of 1945 all of the Pacific invasions and almost every Pacific air strike and raid were participated in. This includes

* Winter Veterans Administration Hospital, Topeka, Kansas.

the invasions of the Marshall, Mariana, Caroline, Philippine, Bonin, and the Ryukyus Islands whose highlights were Saipan and Iwo Jima. Two heavy surface engagements off the Phillippines and also the Okinawa campaigns were experienced. Besides this were the lesser campaigns for our task force in support of part of the New Guinea campaigns, the invasion of Palau and almost thirty air strikes on various Japanese points from such minor raids as those on Yap to those first carrier based air raids on Truk, Tokyo, the Philippines and the Chinese coast. Each air strike lasted 1 to 3 days and often was carried on within sight of land.

The men on this ship saw several severe tropical typhoons, in one of which three destroyers like our own capsized with almost all hands lost. They crossed and re-crossed the equator over twenty times. They saw half a dozen large carriers such as the Franklin and Bunker Hill in flames; they saw hit and helped escort from the Japanese coast at terrifyingly low speeds our own cruisers and destroyers which had been damaged by aerial torpedoes and kamikazes. They had near misses from a few bombs and a very near miss by a suicide plane. They underwent approximately one hundred enemy air raids and saw many enemy airplanes shot down overhead, accounting for at least 8 themselves.

All in all, they experienced a great deal. However, they had tremendous protection from our own carrier based planes and from the task forces' hundreds of antiaircraft guns, so that the danger from combat, though quite real, was not usually terrifying. The attacks on our task force lasted at most for thirty to sixty minutes at a time. However, the most disagreeable part of the whole thing was to most of us the awful monotony between periods of battle. Every time the task force went out the ships kept underway at least thirty days, once forty-five days and during the Okinawa campaign were scheduled to keep underway for over three months. At the end of the forty-five day period we were eating rice, beans, and stew, having even run out of most of our dehydrated foods. And when at the end of one of these cruises we made a port, we found ourselves in a desolate coral atoll, among the first arrivals.

In the beginning there were no recreational facilities at all. The atolls were chosen solely as being good anchorages at convenient logistic points for floating storehouses. When recreational facilities were established they were at most a native hut in which a bar was set up for the officers and the inevitable wire empty compound was constructed for the enlisted men. The stay in those ports averaged about seven days during which time the enlisted man was unusually lucky to get off the ship twice for a liberty. And then a liberty consisted of only about three hours on a small desolate island where he got a maximum of three cans of beer, more usually two, and often warm at that. Few men got on the beach more than fifteen

times during those eighteen months. And, what was even more difficult, during the period from March 1944 until June 1945 no woman was ever seen.

The name of the ship in itself is very significant. The USS The Sullivans was named in honor of the five Sullivan brothers who all lost their lives when the USS Juneau was lost early in the war. Their name and the Sullivan family's sacrifice for the war effort was built up into a minor "cause celebré." A tremendous amount of publicity was given to the Sullivan brothers, the Sullivan family and to the ship named after them. A separate war bond drive with special posters was established to build the ship. Sullivan families all over the country made contributions. The launching of the hull was attended with much fanfare. She became an extremely well known ship and the men who served aboard her were associated with, and identified themselves with a popular and glamorous unit. Later a motion picture was made of the lives of the Sullivan brothers and was shown throughout the country, the fleet and on this ship. Many newspaper and magazine articles appeared praising the ship, its actions, and its crew. All of these articles trickled back to the crew through letters from home and aided in sustaining the men's opinion of themselves as an important group.

Shortly after reaching the combat area, a large green shamrock was painted on the forward stack and on the whaleboats so that the ship was quickly recognizable. And recognized it was, for invariably when it went along side to pass mail or fuel from large ships, their bands, if playing, would quickly switch to something on the order of "When Irish Eyes are Smiling." On St. Patrick's day the Admiral would remember to send greetings. In port, when its men answered the usual question, "What ship are you from?", someone was sure to say, "Oh yes, you're the ship named after the Sullivan brothers, with her twenty-five or thirty men named Sullivan aboard." The ship was well liked as a smart, able, colorful ship, and this was reflected in the proud attitude of all the men serving aboard her.

During the pre-commissioning stage all the men were quartered at the receiving ship in one draft assigned to the ship. During this period they grew to know one another, their chiefs and many of their officers and received intensive instruction in the duties of their rates at various shore-based schools. They were also given lectures on some of the new habits and ways of life they would need aboard ship, 80% of them never having been to sea before. Motion pictures of shipboard hygiene as well as the usual first aid and sex hygiene motion pictures were shown to them. During this period every man was given a chest X-ray, complete dental treatment, and an attempt was made to have individual interviews. This was continued aboard ship during the first few weeks in an attempt to weed out potentially unstable individuals. As the men were observed during the shakedown,

personality evaluations could be made in more detail. Through this procedure about half a dozen frank neuropsychiatric cases were uncovered and, by the end of the period, approximately forty men were transferred as being inept or not adaptable. This was a routine procedure, for about fifty men in excess of the normal complement were taken aboard at the beginning of the shakedown cruise to allow for misfits.

The day of the commissioning a party was held in one of the large hotels for all hands and their wives and friends. This afforded an excellent opportunity for the Commanding Officer to address the ship's company in an informal way, explaining to them the task that lay ahead.

The ship's first Captain was a very exacting, demanding taskmaster. Over eighty per cent of the men came to his ship directly from boot-camp. Only one third of the officers had ever been to sea which means only seven had any first hand idea of their jobs. However, by an intensive pre-commissioning period and a strenuous shakedown training program, the officers and men were forced to learn their jobs thoroughly. This particular Captain was an excellent organizer and administrator but had the unhappy genius for making all his subordinates miserable. At the end of five months overseas duty most officers were scheming some way to get away from him twenty-four hours a day.

Yet through his very faults and terrorism he made every officer learn his job well, insisting that they become proficient in various aspects of ship handling, gunnery and navigation so that almost all officers developed a full confidence in their own abilities and the men, in their leaders. Severe as he was with the officers he was lenient with the chiefs and other enlisted men, and he instituted several policies which were materially valuable to the happiness, contentment, and efficiency of the crew. In all fairness to him it must be said, that when he was relieved, he left a very efficient ship and a well-trained but very unhappy demoralized group of officers. Those men, however, who did not come in direct contact with him, were in good spirits.

The new Captain, a particularly pleasant, easygoing and extremely friendly person, was the perfect relief. He was content to have the officers run the ship and their own departments. The wardroom became a place of cheer; the bridge gang was able to live in peace, and contentment reigned.

Among the important policies the first Captain established was a stern discipline of the officers who were expected to learn their jobs, maintain the ship, and teach their men. The officers in turn were expected to be stern with their men but in a different way from the Captain's overbearing sternness. He made it clear from the first that the men, especially the chiefs, got preferential treatment in all respects. He insisted that there be no Captain's masts except for the most serious offenses. All other charges had to be handled by the division officers or Executive Officer with conse-

quent smooth settling of the usual troubles enlisted men get into. On the other hand he was quick to have commendatory Captain's mast for any display of heroism or unusually meritorious action. Thus the men soon realized that their discipline was going to be strict but fair, and that they would get recognition for well done jobs. After any action during which any gun crew or the ship as a unit did well, the Captain expressed his appreciation and compliments over the public address system.

A rather different method of watch-standing than that used on most ships was established. Each cruise lasted about thirty days during which the crew was divided into three sections and each section stood the same watch for that cruise. The same men stood the twelve to four, the four to eight, and the eight to twelve watches with no dogging of the watch. Thus the men were able to regulate their daily work and personal routine with greater regularity and much more satisfaction. To allow the men with the twelve to four watch more rest, all the sleeping compartments were kept dimmed and quiet until ten AM and a general rest period was maintained throughout the ship from one to three PM. With this routine everyone was always able to get sufficient rest except during the periods of prolonged or frequent General Quarters.

To enable all the men to get as much rest as possible, dawn and dusk General Quarters were abandoned except on strike days, and then only dawn quarters were held. General Quarters was sounded only when attack was assured, thus avoiding unnecessary false alarms and the "all-clear" sounded as soon as reasonably possible so that the periods of battle alertness were as short as they could be.

A definite policy of not having water hours was set up. During the commissioning and fitting out period the conservation of water was carefully explained to the men. Whenever water consumption became too large, the fact was made known over the public address system and, with the cooperation of the men, water hours never had to be instituted unless the machinery broke down, which happened only a few times. All hands cooperated on conserving water and there was sufficient quantity for everyone without enforced restriction. This was one of the few ships I know of that did not have water hours.

The food was kept at the maximum in quality and quantity that logistics allowed. The Captain insisted that the Paymaster go over the government allowed ration allowance for the men and that the food be as well prepared and tasty as could possibly be turned out. This again was greatly appreciated by the men. On all holidays an especially fine menu was planned including candy, cigars and cigarettes. As far as possible, during prolonged actions and immediately after all action, coffee and sandwiches were served all hands.

From the very beginning of his command the first Captain insisted that

the ship be kept spotless. It is quite difficult to keep a destroyer clean because the deck forces are not large, the compartments are crowded and paint was difficult to obtain in the forward area. Yet the First Lieutenant was compelled to see to it that the job was done and every officer was made personally responsible for the area of the ship under his direct supervision.

It is frequently felt that the dirtier the outfit the more rugged the group. Yet this Captain realized that cleanliness was an important factor in the feeling of well-being, and insisted that the ship, the officers and the men be kept as clean, neat, and well-dressed as was at all possible. The policy paid dividends, for not only did the men feel better and take pride in keeping their quarters neat and livable as a home, but the insistence on cleanliness reduced the incidence of skin diseases, which in hot, humid tropical climates can reach alarming proportions.

One of the largest single factors that maintained the men's excellent spirit was the careful announcement to them at the beginning of each cruise of the aims of that particular operation. This was distinctly not in accordance with the security program but was more than worthwhile. On the first day out of port the Commanding Officer would have assembled on the deck all hands not on watch, and address them in person, and have his announcement carried through the whole ship by the public address system. A detailed account, abstracted from the general Operation Plan was presented, telling our destination, the purpose of the strike, an analysis of our forces, an analysis of the enemy's forces, the date set for "D" Day and any other pertinent data. Then the men could ask any questions desired. The release of anxiety seen in the men when truthfully informed of their destination made the value of this breach of security plainly visible. Once they knew where they were headed and the odds against them they would eagerly pitch into the routine preparations and drills that were only monotony if left without a concrete and immediate goal. Were the strike to be even against such a fortified bastion as Truk or into the China Sea, all hands knew roughly what might be expected, and although the opposition might be expected to be tough, that undefinable feeling of fear of the unknown was dismissed and the general attitude was, "Well, this might be a rough trip, so let's get ready."

That this was so was well demonstrated after a change of command. The new Skipper did not give out such information, and in the beginning only announced the word when the destination was reached. During this period, at the outset of each operation, the men were obviously worried and the main and often sole topic for scuttlebutt was "Where are we going and what are we in for?" The drills lacked the enthusiasm previously demonstrated and the men were visibly anxious. After several trips the former plan was again carried out, with a demonstrable upswing in spirit.

There had been maintained for about ten months a daily newspaper of world news as gleaned from the radio press and supplemented by ship's news, banter and friendly ribbing. On Sundays a special supplement of cartoons, poems and stories submitted by members of the crew was added. The little paper was greeted enthusiastically by all hands and its appearance was awaited each day. It was usually distributed to the crew while they were lined up for midday chow and was useful in breaking the monotony of standing in line. (Standing in line for everything from chow to short arm inspection was always one of the favorite gripes.) The paper was discontinued because of a paper shortage, but a radio program was instituted in its place. While the men were in noon chow line, the communications officer would read over the public address system the daily news as given over the radio press. Added to this was an abstract from the secret naval radio of all the news pertinent to our fleet and task force that could possibly be announced plus the news of the progress of the Marine or Army forces whose operations we were supporting. Thus any of our losses or gains were immediately made known to the crew. Such news of our losses came out in the general press usually after a delay of at least a month. The men were thus taken into the "know" and felt that they belonged to the "inner group." This helped to breach that frequently wide gap between the privileges and information granted the officers as compared to those available to the men.

Following this newscast a thirty minute program of recorded music was broadcast. This music was later replaced by a thirty to sixty minute rebroadcast of popular radio programs available on recordings. In addition to these daily routine broadcasts a powerful radio set was maintained tuned to stateside radio stations and piped to the various living compartments via the public address system.

During actual strike and support days the walkie-talkie radios and the inter-tank and inter-plane radios on the beach-heads were picked up and broadcast giving a most exciting, and almost ringside, account of the battle. The reaction among the crew to the extremely difficult and hazardous fighting by the Marines and Army was immediately evident by their show of sympathy for the ground forces and the realization of the relatively easy and comfortable life aboard ship. Personal gripes dropped to zero.

A religious program was instituted rather late, and was found to be greatly appreciated and very useful. The system was followed exactly as on larger ships although we had only a lay Chaplain. The quartermasters even made up a church pennant which was run up Sunday morning when church services were piped down. Prior to the services a thirty minute period of religious music was played throughout the ship over the public address system. The reaction of the men to these services was clearly

shown by their enthusiastic letters and, for those religiously inclined, a definite need was filled.

For another small group, musical entertainment of a classical nature was available. The ward room had a minor library of recordings which were freely loaned to the men, and a few of the men had small personal collections. Later the ship subscribed to a monthly delivery of good modern and classical selections with which we increased the number of our daily programs.

Only a meagre athletic program could be carried out but aboard ship were available a striking bag, boxing gloves, skipping ropes, wrestling mats, medicine balls and fishing gear. Water polo balls were available for use during swimming call and on beach parties soft balls, gloves and bats, footballs, volley balls, and even a badminton set were at hand. Surprisingly, good use was made of this equipment. Teams were organized by divisions for competition ashore and the best of the players organized as a ship's team to meet the other ships in the squadron. A case of cold beer was put up for the winners and became a hotly contested prize.

Because of the very infrequent beach parties and the short duration of each, alcoholic beverages were at a premium. Beer was carried in large quantities, but locked up, to have it for the men when in port in the advanced bases where beer would be otherwise unavailable. Then it was iced and issued ashore, three cans per man per beach party. But rarely could each man get on more than one beach party in any port.

On very special occasions a can of cold beer was issued to all hands at one meal during the day. The can of beer, though it hit the spot, in itself did not amount to much, but the realization that the Skipper was "putting his neck out" very far to give his men a little extra pleasure did mean a great deal to them. Whiskey was available at sick bay, and dispensed rather freely, especially when the men became soaked and chilled or in other special circumstances not necessarily medical.

A library of about 400 volumes, mostly fiction and mystery, was maintained. No strict check was kept on who had the books, but each time in port word was passed to turn in all books not being read. These were then swapped with other ships thereby adding about seventy-five new titles per month. In addition naval headquarters mailed fifty to sixty new paper books each month. Magazines were also subscribed to.

Movies were held every night on deck while in port and were shown daily underway when possible. Arrangement was made to have an afternoon and evening show for the crew and an evening show for the officers. We were able to swap movies frequently and often had three to four new titles per week even in the battle area. Movies were regularly attended by all hands and were undoubtedly the most popular recreation.

A small amount of photographic gear was accumulated and a small darkroom established. Motion pictures of the ship in action, of various ship functions and parties such as inspections, commendation masts, shell-back initiations and battle shots were made and occasionally shown. Still pictures of most of these events and of individual groups of the men were made and given to the men to mail home. The men were particularly anxious to have pictures of themselves to send home to the folks they had not seen for one to two years.

On a destroyer the medical and surgical facilities as well as skilled personnel are at a minimum. For one period of six months we were never in contact with a shore-based hospital or hospital ship. The only consultation was with larger ships. None of these ships had X-ray equipment large enough for major work. Frequently the best and only procedure was to keep our serious patients aboard and give them the best nursing care possible. Often the second Captain, at his own suggestion, had the sick or injured man moved to his own stateroom while he lived in his sea cabin. This action by the Captain made a profound impression on the whole crew.

Occasionally a man was evacuated to a base hospital, only to be bounced back, labeled "No Disease" after a glaringly inadequate examination. In such instances the Commanding Officer was very prompt in returning the man to the hospital, accompanied by a most vitriolic letter, assuring at least an adequate examination. Adequate dental care was difficult to obtain from the hard-pressed tenders, but an arrangement was always made with larger ships to have their dental officers look after our men. No men had to have teeth pulled because of prolonged lack of attention.

While at sea many enlisted men were transferred to the States to schools or to new construction. Orders for such transfers came from the Bureau of Personnel as requests for so many men of a particular rate. A careful policy, which was previously explained to all the men, was carried out in selecting the most deserving men for transfer. Some ships had used this transfer method to get rid of their undesirable men while the good men found that their good work only served to keep them at sea. On our ship, the very best men knew that they would be rewarded by a very fair chance to get home. In eighteen months about forty per cent of the original ship's company did get back. Some men who could have gone back refused to go, preferring to stay with this ship. After eighteen months of continuous front-line duty the gunnery officer had a minor problem on his hands when he had to send back one of his fire-control men. None of the men eligible wanted to go!

New men continually came aboard in drafts of ten to twenty as replacements. These men were shown through the ship, carefully instructed in their duties by their respective chiefs, interviewed by their officers and

given physical examinations and the inevitable immunization shots. The men were thus quickly oriented on the ship and felt that a sincere interest was being taken in their welfare.

In twenty-one months none of the original ship's complement, after the first weeding out, were evacuated as neuropsychiatric casualties with the exception of one officer, who should have been hospitalized before the ship was commissioned, but whom the Commanding Officer refused to transfer until the officer's work became completely worthless. Of the replacements only two were evacuated, both of whom had had much previous sea duty culminating in serious symptoms of combat fatigue for which they had been examined, yet returned to sea without further study. If the statistics may be weighted by these facts, it may be said that there were no neuropsychiatric casualties developing solely from duty aboard this destroyer in twenty-one months, one and a half years of which were in continuous advanced naval warfare.

In recapitulation it will be seen that none of the factors mentioned could be considered singly as the thing that kept the men going. All the factors mentioned contributed to an intangible element that always seems to avoid lucid description. That is the presence of real harmony of inter-personal relations between the officers, the officers and men, and among the men themselves. There was never a serious or angry argument and never any fights among any of the officers and seldom among the men. And, surprisingly enough, there seemed to be no particularly conscious effort on the part of anyone to be exceedingly polite or likeable. A spirit of good fellowship pervaded the ship and seemed to remain constant in quality. Considering the cramped and unpleasant living conditions the men on a destroyer have and the prolonged and hazardous duty with practically no leave or off-the-ship recreation on this ship, the maintenance of morale at its continued high level was quite remarkable.

An easy-going, yet efficient attitude became manifest. All hands were really confident in their belief that theirs was without a doubt the very best ship afloat; and comparison with sister ships easily sustained this belief. The irritable, hateful, sullen and mean attitude that frequently develops in a closely packed and confined group of men never appeared. There was very little of the particularly distasteful attitude of military overbearingness and seemingly useless discipline during the first Commanding Officer's term and none of it at all during the second Commanding Officer's term. All hands seem to have early adopted the attitude that they had ahead of them a particularly ugly and distasteful job, yet could and would see it through with as little friction but as much ease and pleasure as could possibly be injected into the situation. All hands felt that they were fighting for one another, never against one another.

BOOK REVIEW

Diagnostic Psychological Testing. By DAVID RAPAPORT with the collaboration of MERTON GILL and ROY SCHAFER. Price $12.00. Pp. 573 and 516. 2 volumes. Chicago, Year Book Publishers, 1945.

The reader will find today's best ego psychology in these two volumes, modestly interspersed in the discussion of test rationales. I regretted not finding any syntheses of the various tests in the form of case reports. Without access to them, I wonder if the reader might not gain the opinion that Doctor Rapaport is chiefly seeking nosological diagnoses, whereas in daily clinical practice we actually receive insight from consistent, dynamically related statements about the total personality.

As a layman I received from the volumes a deep and ambivalent impression of this new science which Doctor Rapaport and his collaborators so competently utilize. My mind went back many times to old textbooks of psychology which my high school teachers recommended to me more than twenty years ago—Brentano, Jodl, James. How innocently had psychology begun, hardly to be differentiated from the sublime generalizations of philosophy. How similar these old textbooks had been in their effects to the supportive psychiatric treatment of today. But today psychology has become an interpretative, analytical science that cannot fail to exert traumatic effects on one who meets it unprepared.

Freud once spoke of the deep lesions which science has inflicted in man's narcissism. He mentioned Copernicus who shattered man's belief that he was center of the universe; Darwin, who deprived man of his belief in his uniqueness. Freud added that psychoanalysis has forced man to see the dependencies and weaknesses of his conscious mind. The source of this pervasive injury to man's narcissism, it seems to me, is the philosophy of determinism which underlies all scientific endeavor. Doctor Rapaport's books revive this conviction. In their pages one sees hundreds of "unconquerable souls" caught in the meshes of the tests and, whether willing or not, yielding deeply determined information about themselves.

Some of the tested subjects were eager to be frank and cooperative, while some tried to excape diagnosis, but they did not know that the test situation itself blocked all exits. The subject refusing to tell a story about a picture in order not to give away his secret does not know that his refusal is better evidence for the examiner than anything he might have told. He attempts to disguise his thoughts, he tries to be impersonal, he uses cliches, but whatever he does he betrays himself and projects his weaknesses and strengths indiscriminately upon the large screen where the examiner analyzes them, compares them with the weaknesses and strengths of previously tested subjects, and reduces them to statistically workable units in order to emerge with his diagnosis.

Attention, concentration, concept formation, any number of those ego functions which we like to consider areas of supreme freedom are easily proved by the tests' scatter analysis to be interdependent with emotional, physical, and all other human factors. The grandiose narcissistic dreams of freedom of the will, of the mind, of the spirit must go. In their stead

we get an instrument of social usefulness. At present we may make best use of it for clinical diagnosis. Soon, no doubt, we will be able to use it for prognosis and for objective establishment of treatment results.

The time may come when our teachers, our economic, social and political leaders will be selected on the basis of diagnostic psychological testing. The gigantic mistakes which we are making today in these selections will then have become incredible legends. The attraction of living in a world led by untested persons may appear to the future as peculiar and romantic as life in a smoke-filled cave now appears to us. It seems we must leave the old cave because social reason is stronger than narcissistic dreams. Doctor Rapaport's work is a guide out of the cave. (Paul Bergman).

Comments on the book, from others:

"I like its comprehensiveness and its attention to detail. It appears to be the kind of book that every clinical psychologist will have to have on his desk—a good substantial, meaty volume where the answers to most of his questions can be found. . . . These two books arrive at the opportune moment, just when clinical psychology is about to extend its scope. Workers in this field will now have the necessary instruments with which to advance, and I am sure these volumes will be standard for a long time to come." —Henry A. Murray.

"A systematic, insightful, thoroughly mature and wise approach to the problem of differential personality diagnosis. There has never been anything like it and it will certainly be a pacemaker for all American clinical and personality psychology for a long time. I feel that it might benefit from a lighter touch at times, and from concrete references to specific patterns appearing in certain individuals, so that one could see the whole person or at least a good cross-section as well as the general dynamics. The style is exceptionally lucid and free-flowing. Here and there there are questions of interpretation we would like to discuss; but in no case are we in a position to challenge your judgment, which is consistently broad and human."—Gardner Murphy.

"It should give those who think of psychologists as I.Q. testers something to think about."—Simon H. Tulchin.